LIFE, ACCIDENT AND HEALTH INSURERS

COMPANY NAME: _____ **NAIC Company Code:** _____

Contact: _____ **Telephone:** _____

REQUIRED FILINGS IN THE STATE OF: MONTANA **Filings Made During the Year 2007**

(1) Check-list	(2) Line #	(3) REQUIRED FILINGS FOR THE ABOVE STATE	(4) NUMBER OF COPIES* Domestic State	Domestic NAIC	Foreign State	(5) DUE DATE	(6) FORM SOURCE**	(7) APPLICABLE NOTES
		I. NAIC FINANCIAL STATEMENTS						
	1	Annual Statement (8 ½"x14")	1	1	xxx	3/1	NAIC	A thru N
	1.1	Printed Investment Schedule detail (Pages E01-E25)	1	1	xxx	3/1	NAIC	A thru N
	2	Quarterly Financial Statement (8 ½" x 14")	1	1	xxx	5/15, 8/15, 11/15	NAIC	A thru N
	3	Separate Accounts Annual Statement (8 ½"x14")	1	1	xxx	3/1	NAIC	A thru N
		II. NAIC SUPPLEMENTS						A thru N
	10	Accident & Health Policy Experience Exhibit	1	1	xxx	4/1	NAIC	A thru N
	11	Credit Insurance Experience Exhibit	1	1	xxx	4/1	NAIC	A thru N
	12	Interest Sensitive Life Insurance Products Report	1	1	xxx	4/1	NAIC	A thru N
	13	Investment Risk Interrogatories	1	1	xxx	4/1	NAIC	A thru N
	14	Life, Health & Annuity Guaranty Assessment Base Reconciliation Exhibit	1	1	xxx	4/1	NAIC	A thru N
	15	Life, Health & Annuity Guaranty Assessment Base Reconciliation Exhibit Adjustment Form	1	1	xxx	4/1	NAIC	A thru N
	16	Long Term Care Experience Reporting Forms	1	1	xxx	4/1	NAIC	A thru N
	17	Management Discussion & Analysis	1	1	xxx	4/1	Company	A thru N
	18	Medicare Supplement Insurance Experience Exhibit	1	1	xxx	3/1	NAIC	A thru N
	19	Medicare Part D Coverage Supplement	1	1	xxx	3/1, 5/15, 8/15, 11/15	NAIC	A thru N
	20	Risk-Based Capital Report	1	1	xxx	3/1	NAIC	A thru N
	21	Schedule SIS	1	N/A	N/A	3/1	NAIC	A thru N
	22	Statement of Actuarial Opinion	1	1	xxx	3/1	Company	A thru N, Y
	23	Statement on non-guaranteed elements - Exhibit 5 Int. #3	1	1	xxx	3/1	Company	A thru N
	24	Statement on par/non-par policies – Exhibit 5 Int. 1.1	1	1	xxx	3/1	Company	A thru N
	25	Supplemental Compensation Exhibit	1	N/A	N/A	3/1	NAIC	A thru N
	26	Supplemental Schedule O	1	1	xxx	3/1	NAIC	A thru N
	27	Trusteed Surplus Statement	1	1	xxx	3/1, 5/15, 8/15, 11/15	NAIC	A thru N
	28	Workers' Compensation Carve Out Supplement	1	1	xxx	3/1	NAIC	A thru N
		III. ELECTRONIC FILING REQUIREMENTS						
	30	Annual Statement Electronic Filing	xxx	1	xxx	3/1	NAIC	
	31	March .PDF Filing	xxx	1	xxx	3/1	NAIC	
	32	Risk-Based Capital Electronic Filing	xxx	1	N/A	3/1	NAIC	
	33	Separate Accounts Electronic Filing	xxx	1	xxx	3/1	NAIC	
	34	Separate Accounts .PDF Filing	xxx	1	xxx	3/1	NAIC	
	35	Supplemental Electronic Filing	xxx	1	xxx	4/1	NAIC	
	36	Supplemental .PDF Filing	xxx	1	xxx	4/1	NAIC	
	37	Quarterly Electronic Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
	38	Quarterly .PDF Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
	39	June .PDF Filing	xxx	1	xxx	6/1	NAIC	
		IV. AUDITED FINANCIAL STATEMENTS						
	51	Accountants Letter of Qualifications	1	N/A	N/A		Company	A, B, E, I, J, K, X
	52	Audited Financial Statements	1	1	xxx	6/1	Company	A, B, E, I, J, K, X
	53	Audited Financial Statements Exemption Affidavit	1	N/A	N/A		Company	A, B, E, I, J, K, X
	54	Independent CPA	1	N/A	N/A		Company	A, B, E, I, J, K, X
	55	Notification of Adverse Financial Condition	1	N/A	N/A		Company	A, B, E, I, J, K, X
	56	Report of Significant Deficiencies in Internal Controls	1	N/A	N/A		Company	A, B, E, I, J, K, X
	57	Request for Exemption to File	1	N/A	N/A		Company	A, B, E, I, J, K, X
		V. STATE REQUIRED FILINGS						
	101	Certificate of Compliance	0	0	1	3/1	Domicile	A, B, E, O
	102	Certificate of Deposit	0	0	1	3/1	State	A, B, E, P
	103	Certificate of Valuation	0	0	1	3/1	State	A, B, E, Q
	104	Copy of Annual Statement Montana State Page w/Tax Report	1	0	1	3/1	Company	A, B, E
	105	Filings Checklist Page 1 (with Column 1 completed)	1	1	1	3/1	State	A, B, E
	106	Genetics Program Charge (SAI 26)	1	0	1	3/1	State	A, B, E, R
	107	Holding Company Statement	1	0	0	4/30	State	A, B, E
	108	Insurance Department Financial Examination Report	0	0	1	When available	Domicile	A, B, E, S
	109	Montana Comprehensive Health Association (MCHA) Survey	1	0	1	3/1	State	A, B, E, T
	110	Montana Premium Tax Report & Remittance (SAI 27)	1	0	1	3/1	State	A thru F
	111	Quarterly Premium Tax Prepayment Forms (SAI 22)	1	0	1	4/15, 6/15, 9/15, 12/15	State	A, B, D, E, F, U
	112	Report of Insured Montana Residents	1	0	1	3/1	State	A, B, E, V
	113	Small Employer Group Activity Report (SEHRP-06)	1	0	1	3/1	State	A, B, E, W
	114	State Filing Fees	1	0	1	3/1	State	A, B, C, E, F
	115	Signed Jurat	0	xxx	1	3/1	NAIC	A, B, E, L

***If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and the NAIC and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state.**

****If Form Source is NAIC, the form should be obtained from the appropriate vendor.**

	NOTES AND INSTRUCTIONS (A-K APPLY TO ALL FILINGS)
A	**Required Filings Contact Person**: Montana Insurance Department, Examinations Bureau: 406-444-2040 or Fax 406-444-3497 E-mail Addresses: DeeAnn Glowacki at dglowacki@mt.gov; Cheryl Donovan at cdonovan@mt.gov; Tim Morris at tmorris@mt.gov; Wayne Barker at wbarker@mt.gov
B	**Mailing Address**: Montana Insurance Department Examinations Bureau 840 Helena Avenue Helena, MT 59601
C	**Mailing Address for Filing Fees**: Mailing address is same as above. The fee of $1900 should be included with the premium tax form and payment due March 1. If due date falls on weekend or holiday, deadline is extended to next business day.
D	**Mailing Address for Premium Tax Payments**: Same as B.
E	**Delivery Instructions**: Make checks payable to "Commissioner of Insurance, State of Montana." All filings must be postmarked no later than the indicated due date. If due date falls on weekend or holiday, deadline is extended to next business day. The premium tax return (Form SAI 27) with attachments and any payment is due March 1. A copy of the annual statement Montana State Page should be attached to the tax return. If possible, the tax return should be printed on blue paper. If you are completing tax returns for several affiliated companies within a group, and some or all of the companies have a net amount due, please attach a separate check for each company. DO NOT combine amounts for groups of companies. Note that the tax return requires all companies remit a check for $1900 in payment of all Montana filing and renewal fees, plus additional premium taxes due. In the event your company has overpaid premium taxes in 2006, and the overpayment credit is subsequently confirmed by this Department, the credit must be applied toward 2007 quarterly premium tax prepayments. Montana Administrative Rules pertaining to tax payments: 6.6.2706 Adjustments (1) Over the course of the calendar year, the insurer shall make the periodic payment in the amounts specified by ARM 6.6.2704. Any adjustments in the amounts paid must be made in conjunction with the filing of the report and payment of tax on March 1 of each year. Any credit must be carried forward and used to offset future periodic payments. 6.6.2704 Methods of Calculation (1) Every insurer shall pay its quarterly premium tax obligation as follows: (a) pay an amount equal to 100% of its prior calendar year premium tax in four equal payments, or (b) pay an amount equal to 90% of current year premium tax obligation, as calculated pursuant to 33-2-705(2), MCA, in four equal payments. 6.6.2707 Cessation of Business (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules. 6.6.2708 Application of Refund (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is entitled to a refund, the commissioner may authorize a refund. An insurer is not entitled to receive interest on the refund.
F	**Late Filings**: The commissioner may impose a fine [Sections 33-2-701(7) and 33-2-705(6), MCA] if filings are not made in time provided, or suspend or revoke the certificate of authority of any insurer that fails to pay taxes as required. [Section 33-2-705(5), MCA]

G	**Original Signatures**: Domestic insurers must submit an annual statement with original signatures on the Jurat page. Foreign insurers may use facsimile signatures or reproductions of original signatures on Signed Jurat page.
H	**Signature/Notarization/Certification**: Domestic insurers' annual statement must be verified by the oath of the insurer's president or vice-president and secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation.
I	**Amended Filings**: See NAIC Annual Statement Instructions for guidance on amended filings.
J	**Exceptions from normal filings**: Companies must submit a written request for an exemption or extension to the Department of Insurance. Foreign companies must include a copy of any exemption or extension received by its state of domicile to receive such from Montana.
K	**Bar Codes (State or NAIC):** Montana is not currently using Bar Codes.
L	**Signed Jurat**: Montana waives foreign insurers from filing printed annual statements and NAIC supplements if filed with the state of domicile and the NAIC, and if filed electronically with the NAIC. The Signed Jurat page is due March 1. Facsimile signatures or reproductions of original signatures may be used. In the event that any financial data is refiled or amended, a newly completed Jurat page is required.
M	**NONE Filings**: See NAIC Annual Statement Instructions. Exceptions are noted in the instructions.
N	**Filings new, discontinued or modified materially since last year**: NEW: Medicare Part D Coverage Supplement due to NAIC March 1, May 15, August 15, November 15
O	**Certificate of Compliance**: Each foreign insurer shall file a Certificate of Compliance issued by the public official having supervision of insurance in the insurer's state of domicile. It shall certify that the company is duly organized and authorized to transact insurance therein and the kinds of insurance it is authorized to transact. Due March 1.
P	**Certificate of Deposit**: Each foreign insurer shall file a Certificate of Deposit issued by the official having supervision of insurance in the insurer's state of domicile. It shall certify the amount and the composition of the deposit maintained by the insurer in another state for the protection of all policyholders. Due March 1.
Q	**Certificate of Valuation**: Each foreign insurer shall file a Certificate of Valuation issued by the official having supervision of insurance in the insurer's state of domicile. Due as soon as available.
R	**Genetics Program Charge Form** (SAI 26): Pursuant to Section 33-2-712 MCA, an insurer is required to pay to the Commissioner of Insurance $1.00 per Montana resident insured under any individual or group disability (health) insurance policy in effect on February 1, 2007. Any payment due for Genetics Program Charges should be made by attaching a SEPARATE CHECK FOR THE AMOUNT DUE. A Genetics Program Charge Form is enclosed in your packet if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1.
S	**Insurance Department Financial Examination Report**: A copy of the domicile state examination report of foreign insurers is required to be filed with this Department as soon as the report is filed by the domicile state as a public document. An electronic filing is accepted in lieu of hard copy filing if filed electronically with the NAIC.

T	**Montana Comprehensive Health Association (MCHA) Survey**: This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Form has been revised to include association group – individual market type premiums and to include Medicare Advantage and Medicare Part D Plans as exclusions. Due March 1.
U	**Quarterly Premium Tax Forms and Instructions** (SAI 22): Pursuant to Section 33-2-705(7) MCA, and Montana Administrative Rules 6.6.2701 – 6.6.2709, an insurer operating in Montana is required to remit its 2007 premium taxes on a quarterly basis on or before the 15th day of the following months: April, June, September, and December. 6.6.2704 Methods of Calculation (1) Every insurer shall pay its quarterly premium tax obligation as follows: (a) pay an amount equal to 100% of its prior calendar year premium tax in four equal payments, or (b) pay an amount equal to 90% of current year premium tax obligation, as calculated pursuant to 33-2-705(2), MCA, in four equal payments. 6.6.2707 Cessation of Business (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules. Include with the 2007 quarterly premium tax remittances a completed voucher form SAI 22. Each insurer is required to file the quarterly prepayment forms with the Department even if no payment is due. If no direct business will be written in Montana during 2007, return all four voucher forms marked "zero" with the April 15 filing. The quarterly premium tax prepayment forms contain line-by-line calculation information, along with additional instructions on the reverse of the quarterly forms.
V	**Report of Insured Montana Residents**: This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1.
W	**Small Employer Group Activity Report** (SEHRP-06): This report is enclosed if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1.
X	**Audited Financial Statements**: FOREIGN INSURERS ONLY – Please refrain from submitting the Audited Financial Statements to this office until further notice.
Y	**Statement of Actuarial Opinion**: Domestic insurers are required to submit the actuarial opinion, including a copy of the actuarial report supporting the actuarial opinion together with related actuarial work papers. Due March 1.

General Instructions
For Companies to Use Checklist

Please Note: **This state's instructions for companies to file with the NAIC are included in this Checklist. The NAIC will send mailing labels and other information to all companies but will not be sending their own checklist this year.**

Electronic filing is intended to include filing via the Internet or via diskette with the NAIC. Companies that file with the NAIC via the Internet are not required to submit diskettes to the NAIC.

Column (1) (Checklist) Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an "x" in this column when mailing information to the state.

Column (2) (Line #) Line # refers to a standard filing number used for easy reference. This line number may change from year to year.

Column (3) (Required Filings) Name of item or form to be filed.

The ***Annual Statement Electronic Filing*** includes the annual statement data and all supplements due March 1, per the *Annual Statement Instructions*. This includes all detail investment schedules and other supplements for which the *Annual Statement Instructions exempt* printed detail.

The ***March .PDF Filing*** is the .pdf file for annual statement data, detail for investment schedules and supplements due March 1.

The ***Risk-Based Capital Electronic Filing*** includes all risk-based capital data.

The ***Separate Accounts Electronic Filing*** includes the separate accounts annual statement and investment schedule detail.

The ***Separate Accounts .PDF Filing*** is the .pdf file for the separate accounts annual statement and all investment schedule detail.

The ***Supplemental Electronic Filing*** includes all supplements due April 1, per the *Annual Statement Instructions.*

The ***Supplement .PDF Filing*** is the .pdf file for all supplemental schedules and exhibits due April 1.

The ***Quarterly Electronic Filing*** includes the quarterly statement data.

The ***Quarterly .PDF Filing*** is the .pdf for quarterly statement data.

The ***June .PDF Filing*** is the .pdf file for the Audited Financial Statements.

Column (4) (Number of Copies) Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (E) Task Force modified the 1999 *Annual Statement Instructions* to waive paper filings of certain NAIC supplements and certain investment schedule detail, if such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (EX4) Task Force. XXX appears in the "Number of Copies" "Foreign" column for the appropriate schedules and exhibits.

Column (5) (Due Date) Indicates the date on which the company must file the form.

Column (6) (Form Source) This column contains one of four words: "NAIC," "State," "Company," or "Domicile." If this column contains "NAIC," the company must obtain the forms from the appropriate vendor. If this column contains "State," the state will provide the forms with the filing instructions. If this column contains "Company," the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC *Annual Statement Instructions.* If this column contains "Domicile," the company's state of domicile should provide the document.

Column (7) (Applicable Notes) This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.

MONTANA INSURANCE DEPARTMENT
840 HELENA AVENUE
HELENA, MONTANA 59601
(406) 444-2040

2006 ANNUAL PREMIUM TAX STATEMENT LIFE COMPANIES

Insurer Name			**NAIC Number**
Mailing Address	**City**	**State**	**Zip Code**
State of Domicile	**Tax & Fee Contact Person**	**Contact Person Telephone Number**	
Administrative Office Fax Number	**Toll Free Telephone Number for Policyholder Inquiries**		

SCHEDULE A -- TAXABLE PREMIUM CALCULATION

PREMIUMS

1.	Gross life premiums (Ann. Stmt: L/H-pg 25, ln 1, col 5; Health-pg 30, ln 13, col 1)	$_____	[1]
2.	Direct A & H premiums (Ann. Stmt: L/H-pg 25, ln 1, col 5; Health-pg 30, ln 12, col 1)	$_____	[2]
3.	Membership and policy fees and miscellaneous fees	$_____	[3]
4.	Total Premiums Collected (add lines 1 thru 3)	$_____	[4]

DEDUCTIONS

Dividends paid during the current year but credited to the policyholder in a prior year may not be deducted. Dividends which should have been deducted in a prior year may not be deducted in the current year. Policy coupons are to be considered as dividends for the purpose of this report.

5.	Dividends paid or credited to policyholders on Life policies (Ann. Stmt. L/H-page 25, line 6.5, column 5)	$_____	[5]
6.	Dividends paid or credited to policyholders on A & H policies (Ann. Stmt. L/H-page 25, line 26, column 3)	$_____	[6]
7.	Total Deductions * (add lines 5 and 6)	$_____	[7]

* If the dividend deduction does not match the dividends reported on the Montana state page, attach a separate schedule reconciling the difference.

8.	NET TAXABLE PREMIUMS per 33-2-705(1), MCA (line 4 less line 7)	$_____	[8]

CO. NAME _____ NAIC # _____ STATE OF DOMICILE _____

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SCHEDULE B -- COMPUTATION OF TAX AND FEES

9.	Premium Tax per 33-2-705(2), MCA (2.75% of line 8)	$_____	[9]
10.	Retaliatory Amount per 33-2-709, MCA (from Schedule D, Line 3 or 4)	$_____	[10]
11.	TOTAL TAXES (add lines 9 and 10)	$_____	[11]
12.	Montana premium tax quarterly pre-payments	$_____	[12]
13.	Overpayments of prior year premium taxes (as confirmed by credit letter)	$_____	[13]
14.	20% of "Class B" Certificates of Contribution from the Montana Life & Health Insurance Guaranty Assoc. issued in the years 2001-2005, per 33-10-230, MCA (ATTACH CERTIFICATES OF CONTRIBUTION)	$_____	[14]
15.	100% of Assessments paid in 2006 to the Montana Comprehensive Health Association, excluding HIPAA Plan Liability Assessments per 33-22-1513(6), MCA (PROOF OF PAYMENT AND ASSESSMENT LETTER MUST BE ATTACHED)	$_____	[15]
16.	Empowerment Zone New Employees Tax Credit per 33-2-724, MCA (include copy of certification from Montana Department of Labor and Industry)	$_____	[16]
17.	Gross Deductions (add lines 14, 15 and 16)	$_____	[17]
18.	Allowable Deductions (enter the smaller of line 9 or line 17)	$_____	[18]
19.	Total payments and credits (add lines 12, 13 and 18)	$_____	[19]
20.	If line 11 is larger than line 19, DIFFERENCE is **TAX DUE**	$_____	[20]
21.	**COMPANIES MUST REMIT $1,900 IN PAYMENT OF ALL MONTANA FEES**	$ $1900.00	[21]
22.	**TOTAL REMITTANCE** (add lines 20 and 21)	$_____	[22]
23.	If line 19 is larger than line 11, DIFFERENCE is **ANNUAL TAX OVERPAYMENT**	$_____	[23]

OVERPAYMENT must be carried forward and used to offset future periodic payments.

The above statement, and attached Schedules C and D, are true and correct reports of premiums collected and of authorized deductions pertaining to business transacted in Montana in the past calendar year and are in accordance with the requirements of the applicable statutes.

Title of Officer	Name of Officer (Type or print)
Date	Signature of Officer

TAX RETURN CHECKLIST Did You Remember to:

1. _____ Attach Annual Statement Montana State Page?
2. _____ Include Total Remittance from line 22 (at least $1,900)?
3. _____ Attach documentation for tax credits on lines 14, 15 and 16?
4. _____ Indicate your company's NAIC number on front of the tax form?
5. _____ Attach explanations for any unusual or extraordinary items?
6. _____ Fully complete Schedules C and D and attach them to this statement?

CO. NAME _____ NAIC # _____ STATE OF DOMICILE _____

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SCHEDULE C -- RETALIATORY SCHEDULE
ATTACHMENT TO 2006 ANNUAL PREMIUM TAX STATEMENT - LIFE COMPANIES
STATE OF MONTANA

	(A) MONTANA	(B) STATE OF DOMICILE
1. Montana Net Premiums (from Schedule A, Line 8)		
2. Tax Rate	2.75%	
3. Premium Tax		
4. Annuity Considerations	N/A	
5. Annuity Tax Rate	N/A	
6. Annuity Premium Tax	N/A	
7. Certificate of Authority Continuation Fee per 33-2-708(1)(a), MCA	$ 1900.00	
8. Annual Statement Filing Fee	N/A	
9. Assessment for Insurance Department Operations	N/A	
10. Other (explain)_____	N/A	
11. Other (explain)_____	N/A	
12. Total Montana Taxes & Fees (sum of lines 3 and 7, col. A)		XXXXXXXXXXX
13. Total State of Domicile Taxes & Fees (sum of lines 3, and 6 thru 11, col. B)	XXXXXXXXXXX	

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SCHEDULE D -- CALCULATION OF RETALIATORY TAX
ATTACHMENT TO 2006 ANNUAL PREMIUM TAX STATEMENT - LIFE COMPANIES
STATE OF MONTANA

1. Enter Amount from Schedule C, Line 13, Col. B _____
2. Enter Amount from Schedule C, Line 12, Col. A _____
3. If Schedule D, Line 1 is larger than Schedule D, Line 2 enter difference on this line and transfer this amount to Schedule B, Line 10 _____
4. If Schedule D, Line 2 is larger than Schedule D, Line 1 enter $0 on this line and transfer $0 to Schedule B, Line 10 _____

6.6.2708 Application of Refund (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is entitled to a refund, the commissioner may authorize a refund. An insurer is not entitled to receive interest on the refund.

MONTANA INSURANCE DEPARTMENT **840 HELENA AVENUE** **HELENA, MONTANA 59601** **(406) 444-2040**	**PREMIUM TAX REFUND REQUEST FORM** ***6.6.2708, ARM***

Insurer Name	**NAIC Number**

Mailing Address	**City**	**State**	**Zip Code**

State of Domicile	**Contact Person**	**Contact Person Telephone Number**

Reason for decrease in estimated premium tax liability for 2006.	**Method of calculation for refund.** **Calculation subject to audit by Department**
	A. 2006 Overpayment $_____ 2007 Pre-payment Requirement: B. 100% of 2006 Tax $_____ or C. 90% of 2007 Tax * $_____ **1. 2006 Overpayment $_____** **(A from above)** **2. Prepayment required $_____** **(B or C from above)** **3. Amount of Refund $_____** **(1 minus 2)** *** Please explain in left hand column.**

Title of Officer	**Name of Officer (Type or Print)**
Date	**Signature of Officer**

Subscribed and sworn to before me this_____day of _____, 20 _____.

_____(Notary Public)

Residing at _____

My commission expires _____

11/200

6.6.2707 Cessation of Business (1) If an insurer, on a form approved by the commissioner and under oath, notifies the commissioner that it is no longer writing new or renewing existing insurance policies of any type in the state, the commissioner may waive the periodic payment requirements established in these rules.

MONTANA INSURANCE DEPARTMENT **840 HELENA AVENUE** **HELENA, MONTANA 59601** **(406) 444-2040**	**CESSATION OF BUSINESS NOTIFICATION FORM** ***6.6.2707, ARM***

Insurer Name	**NAIC Number**

Mailing Address	**City**	**State**	**Zip Code**

State of Domicile	**Contact Person**	**Contact Person Telephone Number**

Explanation of adjustment to quarterly tax pre-payment.

Title of Officer	**Name of Officer (Type or Print)**
Date	**Signature of Officer**

Subscribed and sworn to before me this_____day of _____, 20___.

_____(Notary Public)

Residing at _____

My commission expires _____

State of Montana

LIFE AND DISABILITY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: APRIL 15, 2007

Insurer Name:_____

NAIC #_____ Check Number:_____

QUARTERLY TAX PAYMENT CALCULATION:

Mail payment to:
Montana Ins. Dept.
840 Helena Ave.
Helena, MT 59601

1. '06 premium tax liability ***(#9 from tax return)*** or 90% of anticipated 2007 tax $_____
2. Less allowable deductions ***(See instructions on reverse)*** $(_____)
3. Total 2007 quarterly pre-payment ***(line #1 - #2)*** $_____
4. Enter 25% of the amount on line #3 $_____
5. Amount of 2006 overpayment applied to this payment ***(see line #23 of the tax return)*** $(_____)
6. **QUARTERLY AMOUNT REMITTED** ***(#4 - #5)*** **$**_____

(Instructions on Reverse)

SAI-22 (10/06)

State of Montana

LIFE AND DISABILITY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: SEPTEMBER 15, 2007

Insurer Name:_____

NAIC #_____ Check Number:_____

QUARTERLY TAX PAYMENT CALCULATION:

Mail payment to:
Montana Ins. Dept.
840 Helena Ave.
Helena, MT 59601

1. '06 premium tax liability ***(#9 from tax return)*** or 90% of anticipated 2007 tax $_____
2. Less allowable deductions ***(See instructions on reverse)*** $(_____)
3. Total 2007 quarterly pre-payment ***(line #1 - #2)*** $_____
4. Enter 25% of the amount on line #3 $_____
5. Amount of 2006 overpayment applied to this payment ***(see line #23 of the tax return)*** $(_____)
6. **QUARTERLY AMOUNT REMITTED** ***(#4 - #5)*** **$**_____

(Instructions on Reverse)

SAI-22 (10/06)

State of Montana

LIFE AND DISABILITY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: JUNE 15, 2007

Insurer Name:_____

NAIC #_____ Check Number:_____

QUARTERLY TAX PAYMENT CALCULATION:

Mail payment to:
Montana Ins. Dept.
840 Helena Ave.
Helena, MT 59601

1. '06 premium tax liability ***(#9 from tax return)*** or 90% of anticipated 2007 tax $_____
2. Less allowable deductions ***(See instructions on reverse)*** $(_____)
3. Total 2007 quarterly pre-payment ***(line #1 - #2)*** $_____
4. Enter 25% of the amount on line #3 $_____
5. Amount of 2006 overpayment applied to this payment ***(see line #23 of the tax return)*** $(_____)
6. **QUARTERLY AMOUNT REMITTED** ***(#4 - #5)*** **$**_____

(Instructions on Reverse)

SAI-22 (10/06)

State of Montana

LIFE AND DISABILITY INSURERS
QUARTERLY PREMIUM TAX PAYMENT
DUE DATE: DECEMBER 15, 2007

Insurer Name:_____

NAIC #_____ Check Number:_____

QUARTERLY TAX PAYMENT CALCULATION:

Mail payment to:
Montana Ins. Dept.
840 Helena Ave.
Helena, MT 59601

1. '06 premium tax liability ***(#9 from tax return)*** or 90% of anticipated 2007 tax $_____
2. Less allowable deductions ***(See instructions on reverse)*** $(_____)
3. Total 2007 quarterly pre-payment ***(line #1 - #2)*** $_____
4. Enter 25% of the amount on line #3 $_____
5. Amount of 2006 overpayment applied to this payment ***(see line #23 of the tax return)*** $(_____)
6. **QUARTERLY AMOUNT REMITTED** ***(#4 - #5)*** **$**_____

(Instructions on Reverse)

SAI-22 (10/06)

QUARTERLY TAX PAYMENT INSTRUCTIONS:

Line #2 Instructions:

The quarterly amounts should be reduced by subtracting the following **allowable deductions:**

A. Anticipated 2007 tax offsets (20% of Montana Life and Health Insurance Guaranty Association assessments paid during tax years 2002-06): $____________________

B. Montana Comprehensive Health Association assessments: $____________________
(excluding HIPAA Plan liability asssessments)

Total allowable deductions to transfer to line #2 *(on front)*: $____________________

Other Instructions:

Do not combine amounts for affiliated companies on a single check.

If the amount on line #3 is zero or a negative amount: Enter zero on line #3 and #6 on all 4 payment vouchers and return all 4 vouchers to this office by April 15, 2007.

If insurer deems the total 2007 quarterly pre-payment requirement on line #3 to be a minimal amount (less than $100), combine all 4 payments in one check, complete all 4 vouchers and submit the payment on or before April 15, 2007.

If premium writings have declined from the previous year, you may substitute the amount on line #1 with an amount equaling 90% of the 2007 anticipated premium tax.

If you have any questions please contact our office at (406) 444-2040.

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